Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BAYLOR SURGICARE
3920 WORTH ST
DALLAS TX 75246-1699

Respondent Name
ACE AMERICAN INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 15

MFDR Tracking Number
M4-12-3184-02

MFDR Date Received
June 21, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CPT 14020 was billed for $3525.00. Medicare workers' comp allows this CPT under facility code 11 (Dallas County), to be reimbursed at $1564.91. . . . ***According to TWCC, title 28, rule 134.402, all Texas workers' compensation participants (ARCMI) shall apply the Medicare program reimbursement methodologies. The participant (ARCMI) shall apply the Medicare payment policies for services by reimbursement amount multiplied by 213.3%***"

Amount in Dispute: $391.86

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response for consideration in this dispute.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
February 3, 2012	Ambulatory Surgery Services	$391.86	$391.86

FINDINGS AND DECISION

This amended findings and decision supersedes all previous decisions rendered in this medical fee dispute between the above requestor and respondent.

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, sets out the reimbursement guidelines for facility services provided in an ambulatory surgical center.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 76 – BILLING IS GREATER THAN SURGICAL SERVICE FEE.

- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- 1014 – THE ATTACHED BILLING HAS BEEN RE-EVALUATED AT THE REQUEST OF THE PROVIDER. BASED ON THIS RE-EVALUATION, WE FIND OUR ORIGINAL REVIEW TO BE CORRECT. THEREFORE, NO ADDITIONAL ALLOWANCE APPEARS TO BE WARRANTED.

Issues

1. Are the disputed services subject to a contractual fee agreement?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute, or a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011.
2. This dispute relates to services performed in an ambulatory surgical center (ASC) with reimbursement subject to the provisions of 28 Texas Administrative Code §134.402, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.402(f)(1)(A), reimbursement for non-device intensive procedures shall be the Medicare ASC facility reimbursement amount multiplied by 235 percent, unless an ASC facility or surgical implant provider requests separate reimbursement for an implantable. Review of the submitted documentation finds no request for separate reimbursement of implantables.
3. Under the Medicare ASC payment system, payable services are assigned standard base payment rates listed in Addenda AA and BB, published quarterly by the Centers for Medicare and Medicaid Services (CMS). Payment rates are geographically adjusted based on a 50 percent labor related share using the annual pre-reclassification wage index publically available through the CMS website. Reimbursement for the disputed services is calculated as follows:
   - Per Addendum AA, procedure code 14020 has a payment rate of $676.48. This amount multiplied by fifty percent is $338.24. This amount multiplied by the 2012 wage index for Dallas of 0.9844 is $332.96. The geographically adjusted labor related share is added to the non-labor related portion for a total Medicare reimbursement amount of $671.20. This amount multiplied by 235% yields a MAR of $1,577.32.
4. The total recommended payment for the services in dispute is $1,577.32. The amount previously paid by the insurance carrier is $1,173.05. The requestor is seeking additional reimbursement in the amount of $391.86. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $391.86.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $391.86, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	March 18, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.